Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7003 2260 0000 9971 8831

March 17, 2009

Barbara Currin, Administrator
Ometta Vent Care Services Inc
3140 Harbor Lane N STE 250
Plymouth, MN 55447

Re: Licensing Follow Up visit

Dear Ms. Currin:

This is to inform you of the results of a facility visit conducted by staff of the Minnesota Department of Health, Case Mix Review Program, on January 6, 7, and 8, 2009.

The documents checked below are enclosed.

__X__ Informational Memorandum
Items noted and discussed at the facility visit including status of outstanding licensing correction orders.

__X__ MDH Correction Order and Licensed Survey Form
Correction order(s) issued pursuant to visit of your facility.

__X__ Notices Of Assessment For Noncompliance With Correction Orders For Home Care Providers

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to call our office if you have any questions at (651) 201-4301.

Sincerely,

Jean M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Jocelyn Olson, Office of the Attorney General
Deb Peterson, Office of the Attorney General
Office of Health Facility Complaints
Mary Henderson, Program Assurance

01/07 CMR1000

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7003 2260 0000 9972 8831

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR CLASS A HOME CARE PROVIDERS

March 17, 2009

Barbara Currin, Administrator
Ometta Vent Care Services Inc
3140 Harbor Lane N STE 250
Plymouth, MN 55447

RE:QL23485004

Dear Ms. Currin:

On January 6, 7, and 8, 2009, a reinspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of correction orders issued during an survey completed on June 9, 10, 11, and 12, 2008, with correction orders received by you on July 10, 2008.

The following correction orders were not corrected in the time period allowed for correction:

1. MN Rule 4668.0040 Subp. 1 **$250.00**

Based on record review and interview, the licensee failed to provide clients with a written notice related to the procedure for making a complaint for two of two clients (A1 and A2) reviewed. The findings include:

Clients A1 and A2 records lacked evidence the clients had not been provided with a written notice related to the procedure for making a complaint. When interviewed on June 11, 2009 the administrator confirmed the clients did not receive a written notice of the complaint procedure.

TO COMPLY: A licensee that has more than one direct care staff person must establish a system for receiving, investigating, and resolving complaints from its clients.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $250.00.

2. MN Rule 4668.0075 Subp. 2 **$100.00**

Based on record review and interview the licensee failed to ensure employees received complete orientation to home care for three of three (AA, AB, and AC) employees reviewed the findings include:

Employees AA, AB, and AC records lacked evidence the employees received training on the overview of the regulations, handling of emergencies and use of emergency services, reporting the maltreatment of vulnerable minors or adults, handling of client complaints, and the services of the ombudsman. When interviewed on June 10, 2008 the administrator stated they had been trained in the bill of rights but not any of the other areas.

TO COMPLY: The orientation required by subpart 1 must contain the following topics:

A. an overview of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

B. handling of emergencies and use of emergency services;

C. reporting the maltreatment of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557;

D. home care bill of rights;

E. handling of clients' complaints and reporting of complaints to the Office of Health Facility Complaints; and

F. services of the ombudsman for older Minnesotans.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $100.00.

3. MN Rule 4668.0100 Subp. 2 **$350.00**

Based on observation, record review and interview the licensee failed to ensure unlicensed personnel were trained in medication administration and reported the administration of pro re nata medications (PRN) to the registered nurse (RN) for two of two unlicensed personnel (AB and AC) reviewed. The findings include:

Employee AB was hired on May 6, 2008 as an unlicensed care giver. Employee AB was observed on June 10, 2008 administering medications to client A1. Employee AB's record lacked evidence she had received training by a registered nurse in medication administration. When interviewed on June 10, 2008 employee AB indicated she was a trained medication aide (TMA) and had worked as a TMA at her previous employment. When interviewed on June 10, 2008 the administrator confirmed employee AB had not received medication administration training or competency evaluation at this agency.

Client A1s' May 2008 medication administration record (MAR) indicated that on May 10, 2008 client A1 received a PRN dose of Tylenol 650mg per G-tube administered by employee AC, an unlicensed staff. Client A1s' record lacked evidence the administration of this PRN medication was reported to the registered nurse. When interviewed on June 10, 2008 the RN stated the

TMA was to tell the RN of the need for the PRN medication, the RN was to assess the client, and then the PRN medication would be given. The RN confirmed she had not been informed within 24 hours that client A1s'had been given.

TO COMPLY: A person who satisfies the requirements of subpart 5 may administer medications, whether oral, suppository, eye drops, ear drops, inhalant, topical, or administered through a gastrostomy tube, if:

A. the medications are regularly scheduled;

B. in the case of pro re nata medications, the administration of the medication is reported to a registered nurse either:

(1) within 24 hours after its administration; or

(2) within a time period that is specified by a registered nurse prior to the administration;

C. prior to the administration, the person is instructed by a registered nurse in the procedures to administer the medications to each client;

D. a registered nurse specifies, in writing, and documents in the clients' records, the procedures to administer the medications; and

E. prior to the administration, the person demonstrates to a registered nurse the person's ability to competently follow the procedure.

For purposes of this subpart, "pro re nata medication," commonly called p.r.n. medication, means a medication that is ordered to be administered to or taken by a client as necessary.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $350.00.

5. MN Rule 4668.0100 Subp. 4 **$350.00**

Based on observation, record review and interview, the licensee failed to ensure there were written procedures in the client's record for one of one current client (A1) reviewed. The findings include:

Client A1's plan of care dated April 24, 2008 indicated client A1 received tracheotomy care, tube feeding, medications per g-tube, continuous use of a ventilator at night, nebulizer treatments, and range of motion from unlicensed care givers. There were no written directions for how to do these procedures in the client's record. When interviewed, June 10, 2008 the registered nurse confirmed there were no written procedures in the client's record and there were no written procedures at the nurse's station or in the client's apartment.

When interviewed, June 10, 2008 the administrator stated there were policies and procedures for checking for residual, tracheotomy care, tube feeding, and medications per g-tube, vent care and nebulizer treatments at the office and provided a copy for review.

TO COMPLY: A person who satisfies the requirements of subpart 5 may perform delegated medical or nursing and assigned therapy procedures, if:

A. prior to performing the procedures, the person is instructed by a registered nurse or therapist, respectively, in the proper methods to perform the procedures with respect to each client;

B. a registered nurse or therapist, respectively, specifies, in writing, specific instructions for performing the procedures for each client;

C. prior to performing the procedures, the person demonstrates to a registered nurse or therapist, respectively, the person's ability to competently follow the procedures; and

D. the procedures for each client are documented in the clients' records.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $350.00.

6. MN Rule 4668.0100 Subp. 9 **$350.00**

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) supervised unlicensed personnel who performed services that required supervision for two of two clients' (A1 and A2) records reviewed. The findings include:

Client A1 began receiving services, April 28, 2008 which included tracheotomy care, tube feeding, and medication administration, range of motion and assistance with activities of daily living. Client A2 began receiving services, March 28, 2008 which included medication administration ventilator care, tube feeding, tracheotomy care, and assistance with activities of daily living. Client A1 and A2 s' records lacked evidence that a supervisory visit was completed every 14 days.

When interviewed, June 10, 2008 both the administrator and the RN stated they were not aware that supervisory visits needed to be completed.

TO COMPLY: After the orientation required by subpart 8, a therapist or a registered nurse shall supervise, or a licensed practical nurse, under the direction of a registered nurse, shall monitor persons who perform home health aide tasks at the client's residence to verify that the work is being performed adequately, to identify problems, and to assess the appropriateness of the care to the client's needs. This supervision or monitoring must be provided no less often than the following schedule:

A. within 14 days after initiation of home health aide tasks; and

B. every 14 days thereafter, or more frequently if indicated by a clinical assessment, for home health aide tasks described in subparts 2 to 4; or

C. every 60 days thereafter, or more frequently if indicated by a clinical assessment, for all home health aide tasks other than those described in subparts 2 to 4.

If monitored by a licensed practical nurse, the client must be supervised at the residence by a registered nurse at least every other visit, and the licensed practical nurse must be under the direction of a registered nurse, according to Minnesota Statutes, sections 148.171 to 148.285.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $350.00.

7. MN Rule 4668.0130 Subp. 3 **$300.00**

Based on record review and interview, the licensee failed to ensure that unlicensed persons who performed home health aide tasks successfully completed training or demonstrated competency in the required topics, for two of two unlicensed employee (AB and AC) record reviewed. The findings include:

Employees AB and AC were hired on May 6, 2008 and January 14, 2008 respectively as an unlicensed personnel to perform home health aide tasks. There was no record of employee AB or AC receiving training in observation, reporting and documentation of client status, maintenance of a clean safe, and healthy environment, appropriate and safe techniques in personal hygiene, grooming, bathing, skin care, care of the teeth and gums, assistant with toileting, adequate nutrition, basic meal preparation, and special diets, communication skills, and physical, emotional and developmental needs of clients. When interviewed, June 11, 2008 the administrator confirmed there was no record of the unlicensed employee receiving the training. When interviewed on June 10, 2008 employee AB stated she had not been trained by the RN. She said she had been trained by unlicensed care aides.

TO COMPLY: The competency evaluation tests must be approved by the commissioner.

A. To qualify to perform home health aide tasks, the person must pass the following:

(1) a practical skill test, administered by a registered nurse, that tests the subjects described in subpart 2, items E, F, I, M, and N; and

(2) a written, oral, or practical test of the topics listed in subpart 2, items A to D, G, H, and J to L.

B. To qualify to perform home care aide tasks, the person must pass the competency evaluation for home health aide tasks, or the following:

(1) a practical skill test, administered by a registered nurse, that tests the subjects described in subpart 2, items E and F; and

(2) a written, oral, or practical test of the topics in subpart 2, items A to D and G.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $300.00.

8. MN Rule 4668.0140 Subp. 1 **$250.00**

Based on record review and interview the licensee failed to ensure a written service agreement was developed for two of two clients (A1 and A2) reviewed. The findings include:

Clients A1 and A2 began receiving services on April 28, 2008 and March 28, 2008 respectively.

Client A1 and A2 records lack evidence that a service agreement had been developed. When interviewed, June 10, 2008 the administrator confirmed service agreements had not been developed.

TO COMPLY: No later than the second visit to a client, a licensee shall enter into a written service agreement with the client or the client's responsible person. Any modifications of the service agreement must be in writing and agreed to by the client or the client's responsible person.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $250.00.

9. MN Rule 4668.0150 Subp. 2 **$350.00**

Based on record review and interview the licensee failed to ensure medications and treatment were administered at ordered for two of two clients (A1 and A2) reviewed. The findings include:

Client A1 had a physician order dated April 24, 2008 for normal saline (NS) 0.9% 200cc's every four for four times daily to flush the g-tube. The April 2008 medication administration record (MAR) indicated the client only received the g-tube, NS flush twice a day on April 25, 26, 27, 28, 29, and 30, 2008.

The May 2008 MAR indicated the client received the g-tube, NS flush three times a day, instead of four times daily as ordered, on May 4, 5, 6, 7, and 11, 2008, two times daily on May 1, 2, 25, 26, 27, 28, 29, and 30, 2008, once daily on May 9, 14, and 15, 2008. It was not documented as being administered on May 8, 17, 18, 19, 20, 21, 22, 23, and 24, 2008.

Client A1s' May 2008 MAR indicated the client had an order dated May 9, 2008 for a PICC Line dressing change, change the PICC Line cap every three days and that the PICC Line was to be flushed with five cc's of normal saline twice daily. The May 2008 MAR lacked documentation the dressing change and cap change to the PICC Line was done on May 11, 14, 17, and 29, 2008. The PICC Line was documented as being flushed with normal saline one time a day, instead of the five times daily as ordered, on May 12, 14, 15, 19, 21, 22, 23, 26, and 29, 2008 and was not documented as ever being flushed with normal saline on May 11, 13, 16, 17, 18, 20, 24, 25, 27, 28, and 20, 2008.

When interviewed, June 10, 2008 the registered nurse (RN) confirmed the above treatments were not documented as being given. When interviewed the same day the licensed practical nurse stated the reason why the treatment to the PICC line was not documented as being done on May 11, 14, 17, and 29, 2008 was because they did not get the supplies until May 20, 2008.

Client A2s' record contained a physician's order dated March 28, 2008 for Albuterol-impratropium (Duonebs) four times daily and Albuterol-impratropium (Combivent) 4 puffs four times daily. Client A2s' April 2008 medication administration record lacked evidence the Albuterol-impratropium (Duonebs) were administered to the client. The April 2008 MAR also indicated the Combivent was only administrated one time on April 1, 2, 3, 4, 5, 6, 7, 8, and 9, 2008.

Client A2 also had a medication administration order dated March 28, 2008 for Amlodipine (Norvasc) 10 milligrams (mg) one tablet daily. The April 2008 MAR indicated the Amlodipine was administered twice a day on April 1, 2, 3, 5, and 6, 2008. The Amlodipine was not administered to the client on April 4, 2008. The April 2008 MAR also indicated the client was to receive Nystatin external powder applied to skin twice a day. The Nystatin was documented as being applied once on April 1, 2008 and not applied on April 2, 3, 4, 5, and 6, 2008. The April 2008 MAR also indicated the client was to receive 100 milliliters (ml) of water by feeding tube three times daily. The MAR indicated the client received the water twice daily on April 2, 2008, once daily on April 3, 2008, that it was not given on April 4, 5, and 6, 2008. The April 2008 MAR indicated the client was to receive tracheotomy care twice a day and g-tube care twice a day. These treatments were documented as being done only once a daily on April 1, 3, 7, and 8, 2008 and not documented as being done on April 2, 4, 5, 6, and 7, 2008. Client A2 was hospitalized, April 9, 2008 and returned from the hospital April 25, 2008 with orders for Pepcid 20mg every morning, Depakote 250 mg twice daily, Septra DS one tablet twice daily, Duonebs three times daily, Geodon 20mg twice daily, Lorazepam 2 mg every eight hours, and 200 cc's of free water every eight hours per feeding tube. Client A2s' April 2008 MAR indicated Pepcid 20mg was not given on April 26,2008, Depakote 250mg was not given on April 26, 2008, Septra DS was only given one time on April 26 and 28, 2008, Duonebs were only given twice on April 26, 2008, Geodon 20mg was not given on April 26, 2008, Lorazepam 2mg was not given on April 26, 2008, and only twice on April 30, 2008, and Free water 200cc was not given on April 26, 2008, only once on April 27, 29, and 30, 2008. Client A2s' May 2008 MAR indicated the Lorazepam 2mg was given only once on May 8, 2008, was given twice on May 1, 9, 10, and 22, 2008, the free water 200cc was not documented as being given on May 3, 10, and, 17, 2008, was documented as only being given once on May 4, 11,18,21,24, and 25, 2008, and twice on May 1, 5, 7, 8, 14, and 30, 2008. Client A2s' May 2008 Mar indicated tracheotomy care and G-Tube care was to be completed twice daily. The May 2008 MAR indicated cares were not done on May 3, 4, 10, 11,17, 18,24, and 25, 2008 and were documented as begin completed once daily on May 6 and 30, 2008.

When interviewed, June 10, 2008 the registered nurse confirmed there was no evidence the medications and treatments were given as ordered.

TO COMPLY: Medications and treatments must be administered by a nurse or therapist qualified to perform the order or by a person who performs home health aide tasks under the direction and supervision of the nurse or therapist consistent with part 4668.0100, subparts 2 to 4.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $350.00.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), the total amount you are assessed is: **$2300.00**. This amount is to be paid by check made payable to the **Commissioner of Finance, Treasury Division MN Department of Health,** and sent to the Licensing and Certification Section of the MN Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 within 15 days of this notice.

You may request a hearing on the above assessment provided that a written request is made to the Department of Health, Facility and Provider Compliance Division, within 15 days of the receipt of this notice.

FAILURE TO CORRECT: In accordance with Minnesota Rule 4668.0800, Subp.7, if, upon subsequent re-inspection after a fine has been imposed under MN Rule 4668.0800 Subp. 6, the (correction order has/the correction orders have) not been corrected, another fine may be assessed. This fine shall be double the amount of the previous fine.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided in the section entitled "TO COMPLY." Where a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance on re-inspection with any item of a multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection has been corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your Facility's Governing Body.

If you have any questions, please feel free to give me a call at 651-201-4301.

Sincerely,

Jean M. Johnston

Jean Johnston
Program Manager
Case Mix Review Program

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Jocelyn Olson, Office of the Attorney General
Deb Peterson, Office of the Attorney General
Office of Health Facility Complaints
Mary Henderson, Program Assurance

Minnesota Department of Health
Division of Compliance Monitoring
Case Mix Review Section

INFORMATIONAL MEMORANDUM

PROVIDER: OMETTA VENT CARE SERVICES INC

DATE OF SURVEY: January 6, 7, and 8, 2009

BEDS LICENSED:
HOSP: _____ NH: _____ BCH: _____ SLFA: _____ SLFB: _____

CENSUS:
HOSP: _____ NH: _____ BCH: _____ SLF: _____

BEDS CERTIFIED:
SNF/18: _____ SNF 18/19: _____ NFI: _____ NFII: _____ ICF/MR: _____ OTHER: CLASS A

NAMES AND TITLES OF PERSONS INTERVIEWED:

Barb Currin, Administrator
Carolyn Strong, RN, Director of Nursing
Barbara Rea, Community Manager, Stone Creek Apartments at Medicine Lake Road
James Foster, PCA, Unit Coordinator
Tracy Brown, LPN
Robin Woodbury, PCA
Sharon Palmer, PCA
Erica Benson, PCA
Allen Watson, PCA
Mother of client A14
Esther Moracha, RN
Justina Zakama, PCA
Wonnie Queeglay, RN
Henry Kurumby, RN
Nadine Shannon, Cook
Marie Robinson, PCA
Michele Foster, PCA, TMA
Aja Gwaro, LPN
Della Smith, PCA
Lender Foster, Chief Administrative Officer
Carolyn Smith, Human Resources
Julia Moore, LPN
Amanda Tarpeh, RN
Daughters of client A3
Pearline Townsend, PCA

SUBJECT: Licensing Survey _____ Licensing Order Follow Up: # 1

ITEMS NOTED AND DISCUSSED:

1) An unannounced visit was made to follow-up on the status of state licensing orders issued as a result of a visit made on June 9, 10, 11, and 12, 2008. The results of the survey were delineated during the exit conference. Refer to Exit Conference Attendance Sheet for the names of individuals attending the exit conference.

The status of the correction orders issued as a result of a visit made on June 9, 10, 11, and 12, 2008, is as follows:

1. MN Rule 4668.0040 Subp. 1 Not Corrected $250.00

Based on record review and interview, the licensee failed to provide clients with a written notice related to the procedure for making a complaint for three of three clients (A12, A15 and A16) records reviewed. The findings include:

Client A12 was admitted to the agency on October 28, 2008, client A15 was admitted to the agency on November 18, 2008, and client A16 was admitted to the agency on April 3, 2008.

When interviewed on January 8, 2009, client A15 stated she was not provided with a written notice related to the procedure for making a complaint from the agency.

When interviewed on January 6, 2009, client A12 and client A16 stated they were not provided with a written notice related to the procedure for making a complaint.

When interviewed on January 7, 2009, the director of nursing stated she had observed a blank form to fill out when making a complaint, but she was unaware if there was a written procedure to follow for making a complaint. The reviewer requested a copy of the written procedure for making a complaint from the administrator on January 6, 7 and 8, 2009. A blank form to fill out for making a complaint was provided to the reviewer, but no procedure for making the complaint was provided.

2. MN. Rule 4668.0075 Subp. 2 Not Corrected $100.00

Based on record review and interview, the licensee failed to ensure employees received complete orientation to home care for two of two employees' (AE and AF) records reviewed. The findings include:

Employees AE was hired as a personal care attendant on December 8, 2008, and employee AF was hired as a personal care attendant on November 18, 2008. The agency was unable to provide any evidence employees AE and AF received orientation to the home care requirements.

When interviewed on January 7, 2009, the Human Resource Director stated the agency had not provided any classroom training to any of the new employees, since the agency's files were seized by a government agency (Office of the Attorney General, Medicaid Fraud Control Unit) on October 30, 2008. The Human Resource Director stated prior to October 30, 2008, orientation to the home care requirements was conducted in the classroom at the business office, but no training had been provided in the classroom to any of the employees hired after October 30, 2008.

3. MN Rule 4668.0100 Subp. 2 Not Corrected $350.00

Based on observation, record review and interview, the licensee failed to ensure unlicensed personnel were trained in medication administration and reported the administration of pro re nata medications (PRN) to the registered nurse (RN) for one of one unlicensed employee (AH) reviewed. The findings include:

On January 8, 2009, unlicensed employee AH was observed setting up and administering medications to client A10.

When interviewed on January 8, 2009, employee AH stated he had been employed by the agency for three years. When queried, he indicated he had not been trained, monitored, observed, or competency tested for medication administration by a registered nurse since the June 2008, Health Department survey. Employee AH stated he was trained for medication administration when he attended a class in the community and he received a certificate indicating he was a trained medication aide. He indicated he had not received any medication training from this agency. Unlicensed employee AH stated he trained other unlicensed staff-trained medication aides, in medication administration. He indicated that unlicensed staff were trained at the agency by basically watching him administer medications.

When interviewed January 6, 2009, the owner stated she did not possess training records for any of the employees, since all training records were seized by a government agency (Office of the Attorney General, Medicaid Fraud Control Unit) on October 30, 2008. The owner was unaware if any of the unlicensed employees that administer medications were trained or competency tested for medication administration since the June 2008 Health Department survey.

Unlicensed employee AH was observed administering two 500 mg. tablets of PRN (as needed) Tylenol to client A10 on January 8, 2009. Client A10's record lacked evidence the administration of this PRN medication was reported to the registered nurse.

When interviewed on January 8, 2009, unlicensed employee stated he was unaware of any procedure to follow prior to, or after, the administration of a PRN medication to a client.

When interviewed on January 8, 2009, the director of nursing stated she was hired by the agency one month ago. She stated it was the procedure for PRN medications to be recorded on each clients' individual medication administration record (MAR). She was unaware if there was an agency procedure regarding PRN medications other than the routine recording of all PRN medications on the appropriate client MAR. She indicated she was not aware of any procedure for the reporting prior to, or after, the administration of PRN medications to an agency registered nurse.

4. MN Rule 4668.0100 Subp. 3 **Corrected**

5. MN Rule 4668.0100 Subp 4 **Not Corrected** **$350.00**

Based on observation, record review and interview, the licensee failed to ensure there were written procedures for delegated nursing tasks in the client record for two of two current clients' (A1 and A16) records reviewed. The findings include:

Observations on January 8, 2009, and the client's plan of care dated April 24, 2008, indicated client A1 received care from unlicensed personnel including tracheotomy care twice per shift, oxygen stats every shift, suctioning of his trach and mouth, tube feeding, medications per G-tube, dressing change at the G-tube site, nebulizer treatments, foley catheter care and the use of a CPAP (continuous positive airway pressure) at night. There were no written procedures in the client's record for any of the aforementioned procedures.

Observations and interviews on January 6, 2009, indicated client A16 received tracheotomy care, suprapubic catheter care, gastric tube feeding, and gastric tube feeding site care from unlicensed personnel. There were no written procedures in the client's record for any of the aforementioned procedures.

When interviewed on January 7, 2009, the director of nursing stated the agency procedure book, which contained procedures for delegated nursing tasks, were at the agency business office (located at another address) because the procedure book was currently being updated by the owner.

When interviewed on January 8, 2009, unlicensed employee AH stated he was unaware of a procedure book or written procedures for any of the aforementioned tasks. He indicated if he had a question concerning a procedure, he would call a nurse.

When interviewed on January 7, 2009, the Human Resource Director stated the policy and procedure book is usually kept at the main business office.

6. MN Rule 4668.0100 Subp. 9 Not Corrected $350.00

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) supervised unlicensed personnel who performed services that required supervision for two of two clients' (A1 and A16) records reviewed. The findings include:

Client A1 began receiving services from unlicensed personnel April 28, 2008, which included tracheotomy care, suctioning, tube feeding, Foley catheter care, and medication administration via a gastric tube.

Client A16 began receiving services on April 3, 2008 which include tracheotomy care, suprapubic catheter care, medication administration, and gastric tube feedings. Documentation and observations indicated the aforementioned services were performed by unlicensed employees. Client A1 and A16s' records lacked evidence that a supervisory visit was completed every fourteen days.

When interviewed on January 7, 2009, the director of nursing stated she was not aware supervisory visits were required. The director of nursing confirmed unlicensed staff performed all of the aforementioned delegated nursing tasks.

7. MN Rule 4668.0130 Subp. 3 Not Corrected $300.00

Based on record review and interview the licensee failed to ensure unlicensed personnel who performed home health aide tasks successfully completed training or demonstrated competency in the required topics, for two of two unlicensed employee (AE and AF) records reviewed. The findings include:

Employees AE and AF were hired on December 8, 2008 and November 18, 2008, respectively as unlicensed personnel to perform home health aide tasks. There were no records available for review that employee AE or AF received training in observation, reporting and documentation of client status, maintenance of a clean safe, and healthy environment, infection control, appropriate and safe techniques in personal hygiene, grooming, bathing, skin care, care of the teeth and gums, assistant with toileting, adequate nutrition, basic meal preparation and special diets, communication skills, reading and recording temperature, pulse and respiration; recognition and handling of emergencies, safe transfer techniques and ambulation, range of motion and positioning; and physical, emotional and developmental needs of clients.

When interviewed on January 7, 2009, the Human Resource Director stated the agency did not provide classroom training to new employees since the agency's files were seized by a government agency (Office of the Attorney General, Medicaid Fraud Control Unit) on October 30, 2008. The Human Resource Director stated prior to October 30, 2008, basic home care training classes were conducted in the classroom at the business office, but no classroom training had been provided to any employees hired after October 30, 2008.

When interviewed on January 8, 2009, unlicensed employee AH stated he trained unlicensed employee AE in the areas of positioning, transferring, tube feeding, suctioning, trach cares, bathing, gastric tube cares and catheter care. Employee AH indicated he was a unit coordinator and stated it was his responsibility as the unit coordinator to train newly hired unlicensed staff. He provided the reviewer with a blank copy of a document titled "U/C TRAINING √List", which included the aforementioned tasks. He stated he had completed the training checklist for employee AE and sent the completed checklist back to the main business office. The business office was unable to locate any training documents for employee AE or employee AF.

8. MN Rule 4668.0140 Subp. 1 Not Corrected $250.00

Based on record review and interview the licensee failed to ensure a written service agreement was developed for four of four clients' (A1, A3, A16 and A18) records reviewed. The findings include:

Clients A1, A3, A16 and A18 began receiving services on April 24, 2008, July 23, 2008, April 3, 2008, and November 19, 2008, respectively. The client records lacked evidence a service agreement had been developed.

When interviewed on January 6, 2008, the owner stated the client service agreements were part of the documents which had been seized by a government agency (Office of the Attorney General, Medicaid Fraud Control Unit) on October 30, 2008.

When interviewed on January 9, 2009, family members of client A3 stated the agency never had a service agreement with them for the cares their mother was receiving. They indicated they were the responsible persons for their mother's affairs.

When interviewed on January 6, 2008, client A16 stated he not been requested or offered by the agency to sign any type of a contract for the services he receives. The components of a service agreement were reviewed with him and he stated he never had a service agreement with the agency.

When interviewed on January 7, 2009, the Chief Administrative Officer stated client A18 did not have a service agreement with the agency because the client had not been approved for Medical Assistance.

9. MN Rule 4668.0150 Subp. 2 Not Corrected $350.00

Based on record review and interview the licensee failed to ensure medications and treatments were administered as ordered for two of two clients' (A1 and A16) records reviewed. The findings include:

Client A1's record contained physician orders dated November 28, 2008, to check emergency supplies and equipment for every shift. These supplies and equipment included: current trach size, lubricant, trach ties, trach obturator, circuit kit, battery charger, sterile pump and battery charger. The client's treatment record lacked evidence the supplies and emergency equipment were checked for the night shift on December 4, 5, 26, 2008; for the day shift on December 7, 25, 29, 30, 31, 2008; and for the evening shift on December 15, 30 and 31, 2008.

Client A1's physician orders dated November 28, 2008 ordered the suction canister, suction tubing, and the vent circuit changed weekly. The client's treatment record lacked evidence the suction canister, suction tubing, and the vent circuit were changed during the week of December 1 and the week of December 29, 2008. Physician orders dated November 28, 2008 also indicated the client's G-tube was to be flushed every four hours with 200 cc of 0.9% sodium chloride solution. The treatment record lacked evidence the tube was flushed at midnight and 4 a.m. on December 11, 12 21, 24, 25, 27, 28, 29, 30, 31, 2008; at 8:00 am on December 9, 10, 11, 14 and 31; at 12 noon on December 2, 5, 17, 18, and 31, 2008; at 4 p.m. and 8 p.m. on December 1, 2, 9, 15, 16, 17, 20, 22, 23, 24, 25, 26, 29, 30 and 31, 2008. The physician orders also indicated Promote (a tube feeding solution or an equivalent) was to run continuously at 65 cc per hour. There was no evidence on the client's treatment record the tube feeding was administered during the night shift on December 1, 2, 3, 4, 31, 2008; during the day shift on December 1, 7, 17, 25 and 3, 2008; and during the evening shift on December 1, 2, 6, 18, 31 and 31, 2008.

Client A1 had physician orders dated November 28, 2008 for Miconazole Nitrate 2% cream to be applied twice per day, Lovenox 30 mg to be administered subcutaneously every day, Reglan 5 mg administered every six hours, Lopressor 25 mg. administered three times per day and a Xopenex nebulizer administered three times per day. The treatment record lacked evidence the Miconazole cream was applied on the day shift on December 6, 25, 29, 30 31, 2008; and on the evening shift on December 15, 16, 30 and 31, 2008. There was no evidence on the client's treatment record Lovenox 30 mg. was administered on December 2, 6, 9, 12 and 13, 2008. There was no evidence Reglan 5 mg. was administered at noon on December 8; Lopressor 25 mg was administered at 12 am on December 11; and the nebulizer, Xopenex treatment was administered at noon on December 12, 2008.

Similar problems were identified in the treatment and medication record for Client A16. There was no evidence in the client's record that some medications and treatments were administered as ordered by physician orders dated December 1, 2008. There was no evidence on the medication and treatment records that the following were administered as ordered: Baclofen 10 mg at noon on December 26, 2008; suprapubic catheter care was completed during the night shift on December 30, 31, during the day shift on December 18 and 24, during the evening shift on December 31, 2008; a Mesalt dressing was applied to the client's left trochanter wound and wound care was completed on the client's left thigh wound on December 2, 14 and 26, 2008; the client's PICC (peripherally inserted central catheter) line was flushed with normal saline after use on December 21, 22, 28 and 31, 2008; the PEG (percutaneous endoscopic gastrostomy) tube site was cleansed on the evening shift on December 15, 25 and 31; the trach site was cleaned during the evening shift on December 31; emergency supplies were checked during the night shift on December 30, 31, during the day shift on December 18 and during the evening shift on December 31; the suction tubing and canister were changed at all during the month of December (the order is for the equipment to be changed weekly); Promote feeding solution was administered as ordered during the night shift on December 30 and 31 and during the evening shift on December 29 and 31; Bactrim double strength at 8 p.m. on December 22 and Neurotin at noon on December 26, 2008.

Physician orders dated December 1, 2008 for client A16 indicated the client's blood glucose was to be checked every four hours and sliding scale insulin coverage was ordered for Novolog insulin to be administered based on the results of the blood glucose. According to documentation on the December medication record titled "Diabetic Flow Record", blood glucose was not always tested as ordered and the sliding coverage insulin was not always administered as ordered. Blood glucose testing was not documented as being completed at 7:00 am on December 17; at 11:00 am on December 9, 12, 17, 23, 25, 26; and 8 p.m. on December 10, 22, 2008. According to the physician ordered insulin sliding scale coverage, 2 units of Novolog insulin was to be administered for blood glucose reading of 150-200. Two units of Novolog were not administered as ordered for a blood glucose reading of 152 at 7 a.m. on December 7, 2008. The wrong amount of insulin was administered at 8:00 pm on December 6 for a blood glucose reading of 171. According to documentation, six units of Novolog insulin was administered rather than the physician ordered two units.

When interviewed on January 7, 2009, the director of nursing confirmed it could not be determined if medications and treatments were administered as ordered due to the lack of documentation on medication and treatment records.

2) Although a State licensing survey was not due at this time, correction orders were issued.

3) The following referral/s is/are being made:
i) OHFC- VAA
ii) Local County-MOM
iii) Attorney General-Deb Peterson; Jocelyn Olson

Class A Licensed-Only Home Care Provider

LICENSING SURVEY FORM

Registered nurses from the Minnesota Department of Health (MDH) use this Licensing Survey Form during on-site visits to evaluate the care provided by Class A Licensed-Only Home Care Providers. Class A licensees may also use this form to monitor the quality of services provided to clients at any time. Licensees may use their completed Licensing Survey Form to help communicate with MDH nurses during an on-site regulatory visit.

During an on-site visit, MDH nurses will interview staff, clients and/or their representatives, make observations and review documentation. The survey is an opportunity for the licensee to describe to the MDH nurse what systems are in place to provide Class A Licensed-Only Home Care services. Completing this Licensing Survey Form in advance may facilitate the survey process.

Licensing requirements listed below are reviewed during a survey. A determination is made whether the requirements are met or not met for each Indicator of Compliance. This form must be used in conjunction with a copy of the Class A Licensed-Only Home Care regulations. Any violations of the Class A licensing requirements are noted at the end of the survey form.

Name of Class A Licensee: OMETTA VENT CARE SERVICES INC

HFID #: 23485

Dates of Survey: January 6, 7, and 8, 2009

Project #: QL23485004

Indicators of Compliance	Outcomes Observed	Comments
1. The provider accepts and retains clients for whom it can meet the needs. **Focus Survey** • MN Rule 4668.0140 **Expanded Survey** • MN Rule 4668.0050 • MN Rule 4668.0060 Subp. 3, 4 and 5 • MN Rule 4668.0180 Subp. 8	• Clients are accepted based on the availability of staff, sufficient in qualifications and numbers, to adequately provide the services agreed to in the service agreement. • Service plans accurately describe the needs and services and contain all the required information. • Services agreed to are provided Clients are provided referral assistance.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
2. The provider promotes client rights. **Focus Survey** • MN Rule 4668.0030 • MN Statute §144A.44 **Expanded Survey** • MN Rule 4668.0040 • MN Rule 4668.0170	• Clients' are aware of and have their rights honored. • Clients' are informed of and afforded the right to file a complaint.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
3. The provider promotes and protects each client's safety, property, and well-being. **Focus Survey** • MN Statutes §144A.46 Subd. 5(b) • MN Statute §626.556 • MN Statutes §626.557 **Expanded Survey** • MN Rule 4668.0035	• Client's person, finances and property are safe and secure. • All criminal background checks are performed as required. • Clients are free from maltreatment. • There is a system for reporting and investigating any incidents of maltreatment. • Maltreatment assessments and prevention plans are accurate and current.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** # 1 _X_New Correction Order issued _X_Education Provided
4. The provider maintains and protects client records. **Focus Survey** • MN Rule 4668.0160 **Expanded Survey** [Note: See Informational Bulletin 99-11 for Class A variance for Electronically Transmitted Orders.	• **Client records are maintained and retained securely.** • **Client records contain all required documentation.** • Client information is released only to appropriate parties. • Discharge summaries are available upon request.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met

Indicators of Compliance	Outcomes Observed	Comments
Non-compliance with this variance will result in a correction order issued under 4668.0016.]		____Correction Order(s) issued ____Education Provided **Follow-up Survey** # 1 _X_ New Correction Orders issued _X_ Education Provided
5. The provider employs and/or contracts with qualified and trained staff. **Focus Survey** • MN Rule 4668.0100 • [Except Subp. 2] • MN Rule 4668.0065 **Expanded Survey** • MN Rule 4668.0060 Subp. 1 • MN Rule 4668.0070 • MN Rule 4668.0075 • MN Rule 4668.0080 • MN Rule 4668.0130 • MN Statute §144A.45 Subd. 5 [Note: See Informational Bulletin 99-7 for Class A variance in a Housing With Services Setting. Non-compliance with this variance will result in a correction order issued under 4668.0016.]	• Staff, employed or contracted, have received all the required training. • Staff, employed or contracted, meet the Tuberculosis and all other infection control guidelines. • Personnel records are maintained and retained. • Licensee and all staff have received the required Orientation to Home Care. • Staff, employed or contracted, are registered and licensed as required by law. • Documentation of medication administration procedures are available. • Supervision is provided as required.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** # 1 _X_ New Correction Orders issued _X_ Education Provided
6. The provider obtains and keeps current all medication and treatment orders [if applicable]. **Focus Survey** • MN Rule 4668.0150 **Expanded Survey** • MN Rule 4668.0100 Subp. 2 [Note: See Informational Bulletin 99-7 and 04-12 for Class A variance in a Housing With Services setting with regards to medication administration, storage	• Medications and treatments administered are ordered by a prescriber. • Medications are properly labeled. • Medications and treatments are administered as prescribed. • Medications and treatments administered are documented. • Medications and treatments are renewed at least every three months.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction

Indicators of Compliance	Outcomes Observed	Comments
and disposition. Non-compliance with this variance will result in a correction order issued under 4668.0016.]		Order issued ____Education Provided
7. The provider is licensed and provides services in accordance with the license. **Focus Survey** • MN Rule 4668.0019 **Expanded Survey** • MN Rule 4668.0008 Subp. 3 • MN Rule 4668.0012 • MN Rule 4668.0060 Subp. 2 and 6 • MN Rule 4668.0180 • MN Rule 4668.0220 Note: MDH will make referrals to the Attorney General's office for violations of MN Statutes 144D or 325F.72; and make other referrals, as needed.	• Language requiring compliance with Home Care statutes and rules is included in contracts for contracted services. • License is obtained, displayed, and renewed. • Licensee's advertisements accurately reflect services available. • Licensee provides services within the scope of the license. • Licensee has a contact person available when a para-professional is working.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** # 1 _X_New Correction Order issued _X_Education Provided
8. The provider is in compliance with MDH waivers and variances. **Expanded Survey** • MN Rule 4668.0016	• Licensee provides services within the scope of applicable MDH waivers and variances	*This area does not apply to a Focus Survey.* **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Please note: Although the focus of the licensing survey is the regulations listed in the Indicators of Compliance boxes above, other rules and statutes may be cited depending on what system a provider has or fails to have in place and/or the severity of a violation. The findings, of the focused survey may result in an expanded survey.

SURVEY RESULTS: ____ All Indicators of Compliance listed above were met.

For Indicators of Compliance not met, the rule or statute numbers and the findings of deficient practice are noted below.

1. MN Rule 4668.0065 Subp. 1

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure tuberculosis screening was completed and documented before staff had direct client contact for three of three employees' (AD, AE and AF) records reviewed. The findings include:

Employee AD was hired by the agency on December 1, 2008, as the director of nursing. The employee's personnel file did not contain evidence of tuberculosis screening.

Employee AE was hired by the agency on December 8, 2008, as a personal care attendant and began working directly with the clients on December 11, 2008. The employee's personnel file did not contain evidence of a tuberculosis screening.

Employee was hired by the agency on November 11, 2008, as a personal care attendant. The employee's tuberculosis screening record indicated the employee had a positive reaction to a mantoux test on July 27, 2007, and then had a subsequent negative chest x-ray on July 30, 2007. There was no evidence available for review for a more current chest x-ray result and/or of a negative chest x-ray for a second year after the positive reaction to the mantoux test.

When interviewed on January 7, 2009, the Human Resource Director stated she had requested the results of a mantoux test from both employees AD and AE, but had not received any mantoux tests from either employee. The Human Resource Director stated she thought one negative chest x-ray was adequate for a TB screening after an employee had a positive mantoux test.

2. MN Rule 4668.0100 Subp. 4

INDICATOR OF COMPLIANCE: # 5

Based on observations and interview, the licensee failed to competency test unlicensed employees that completed delegated nursing tasks for five of five clients' (A6, A12, A13, A15 and A16) observed receiving cares. The findings include:

Unlicensed staff were observed performing delegated nursing tasks on all days of the site visit. On January 6, 2009, unlicensed employee AF was observed suctioning client A13's tracheotomy; unlicensed employee AL was observed suctioning client A15 and unlicensed employee AM was observed emptying the urinary Foley catheter bag for client A16. On January 7, 2009, unlicensed employee was observed suctioning client A16. On January 8, 2009, unlicensed employee AH was observed changing the dressings around the tracheotomy and g-tube site, and changing the inner cannula of the trach for client A6; and unlicensed employee AN was observed changing the dressing around client A12's tracheotomy.

When interviewed on January 8, 2009, unlicensed employee AH stated he was a unit coordinator and it was a responsibility of a unit coordinator to train unlicensed employees in the areas of tube feeding, suctioning, gastric tube cares and catheter care. He provided the reviewer with a blank copy of a document titled, "U/C TRAINING √List", which included the aforementioned tasks. Employee AH

indicated he recently trained and completed the U/C training checklist for employee AE. When interviewed on January 8, 2008, employee AE stated she was trained how to do tube feedings, suctioning and working with the ventilators by another personal care attendant. (Employee AE was hired on December 8, 2008 as a personal care attendant). AH stated once a training checklist was completed, the completed checklist was sent back to the main business office. The business office was unable to locate any training or competency documents for any employees.

3. MN Rule 4668.0130 Subp. 1

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview the licensee failed to ensure a registered nurse trained unlicensed personnel who performed home health aide tasks in the required topics, for one of two unlicensed employee (AE) records reviewed. The findings include:

Employee AE was hired on December 8, 2008, as an unlicensed person to perform home health aide tasks. There were no records available for review that employee AE received training in observation, reporting and documentation of client status, maintenance of a clean safe, and healthy environment, infection control, appropriate and safe techniques in personal hygiene, grooming, bathing, skin care, care of the teeth and gums, assistant with toileting, adequate nutrition, basic meal preparation and special diets, communication skills, reading and recording temperature, pulse and respiration; recognition and handling of emergencies, safe transfer techniques and ambulation, range of motion and positioning; and physical, emotional and developmental needs of clients.

When interviewed on January 8, 2009, unlicensed employee AH stated he trained unlicensed employee AE in the areas of positioning, transferring, tube feeding, suctioning, trach cares, bathing, gastric tube cares and catheter care. Employee AH indicated he was a unit coordinator and stated it was his responsibility as the unit coordinator to train newly hired unlicensed staff. He provided the reviewer with a blank copy of a document titled "U/C TRAINING √List", which included the aforementioned tasks. He stated he had completed the training checklist for employee AE and sent the completed checklist back to the main business office. The business office was unable to locate any training documents for employee AE.

4. MN Rule 4668.0160 Subp. 5

INDICATOR OF COMPLIANCE: # 4

Based on record review and interview the licensee failed to ensure all entries in the client record were authenticated with the name and title of the person making the entry for two of two clients' (A1 and A16) records reviewed. The findings include:

December medication and treatment records for clients A1 and A16 contained the initials of the employees that administered the medications and treatments. The agency could not provide the reviewer with a legend of the staff initials and the corresponding name and title of the employee. Therefore, it could not be determined if employee shad the appropriate licensure and training to provide medication administration and treatments to the clients.

When interviewed on January 7, 2009, the director of nursing indicated the employees should be signing their full name and title with their corresponding initials on the medication and treatment records, but verified this was not occurring.

5. MN Rule 4668.0160 Subp. 6

INDICATOR OF COMPLIANCE: # 4

Based on interview, the licensee failed to complete a summary following the termination of services for three of three clients (A19, A20 and A 21). The findings include:

When interviewed on January 6, 2009, the administrator identified three clients (A19, A20, and A21) that were removed by Adult Protection from the care of the agency and transferred to another residence and agency for home care services. When queried, the administrator stated no discharge summaries were completed for any of the three clients when the home care services from this agency were no longer provided.

6. MN Rule 4668.0220 Subp. 8

INDICATOR OF COMPLIANCE: # 7

Based on interview, the licensee failed to provide information identifying some or all of its clients and any other information about the licensee's services to the clients to the reviewer, a representative of the Commissioner. The findings include:

The reviewer arrived at the business address of the agency at 9:00 am on January 6, 2009 and requested to see the administrator. The administrator arrived at 9:15 am. The administrator stated to the reviewer, "Ometta is shutting down and has no clients." The administrator indicated she had a biller that was billing incorrectly, so the "state" (Office of the Attorney General, Medicaid Fraud Control Unit) came in and took all of her computers and about 50 boxes of files which included client records. The administrator showed the reviewer her bare file cabinets. Upon further inquiry, the administrator indicated the state, adult protection, had placed most of her clients their selves. She stated all of her clients had their care transferred to other agencies. The administrator stated Ometta Vent Care continued to provide care for clients at Stone Creek and Stone Leigh apartment buildings in Plymouth until November 15, 2008, at which time "the state started to bring people in to care for the clients." Upon request, the administrator provided the reviewer with a list of clients. The administrator entered on the client list behind the twelve of the eighteen client names, the agency to whom the clients' care was transferred. The administrator indicated by yellow highlighting on the client list, two of the clients that were deceased. There were four clients on the client list that the administrator was unable to identify the agency the clients care was transferred to. The reviewer requested a document on business letterhead from the administrator indicating Ometta Vent Care was not serving any clients currently under the class A license she has from the Minnesota Department of Health. (It was noted upon entrance into the business office located at 3140 Harbor Lane North, Suite 250, Plymouth, there was a Class A license for Ometta Vent Care Services from the Minnesota Department of Health posted on the wall in the lobby area). The administrator refused and called her attorney. She indicated her attorney advised her not to provide the reviewer with the document requested. The reviewer requested to speak with the administrator's attorney. The attorney questioned the reviewer and asked if the document could be mailed rather than provided today. The reviewer stated no, and informed the attorney if the document

was not provided, the reviewer would need to continue with the follow up survey. The administrator left the office are to speak with her attorney in private on the phone and then returned approximately five minutes later and presented the reviewer with a hand written document. The document was a sheet of white paper and the following was written on the paper, "01.06.09 Ometta Vent Care, Inc have no clients under Class A. No client @ or none that OVC is servicing. All clt. has been transferred out. B. Cu------." The reviewer left the agency business office and proceeded to the Stone Creek apartment complex, since pre-survey information gathered indicated persons wearing Ometta Vent Care scrubs attire had been observed in this apartment building on December 29, 2008. Upon the reviewer's arrival at the apartment complex, it was observed on the building directory security intercom numbers, "Ometta" and names of clients at extensions 657, 509, 643, 579, 518 and 630. The reviewer entered 657 into the building security intercom, and the intercom was answered as, "J……., Ometta." The reviewer identified herself as an employee of the Minnesota Department of Health and asked which apartment number the reviewer dialed. The apartment number, 101, was provided, the security door was released and the reviewer entered the apartment complex. The reviewer proceeded to apartment 101 and requested to see the director of nursing. The personal care attendant in apartment 101 identified himself as an Ometta employee. Observed in the apartment living room was a controlled drug count book labeled as Ometta Vent Care Services and hanging on the wall was a piece of paper which noted "Ometta Upcoming Appointments." The director of nursing (DON) arrived at apartment 101 at 11:55 am and identified herself as an employee of Ometta Vent Care. A letter of introduction and a blank client roster was provided to the DON. The DON was instructed to fill out the roster for the clients that were receiving services from Ometta Vent Care. The DON stated some of the clients were receiving care from Ometta Vent Care and other clients were receiving services from another home care agency, Transcare. A client roster was provided to the reviewer at 3:30 p.m. The roster listed sixteen clients. Thirteen of the sixteen clients were the same clients the administrator had indicated were no longer clients of Ometta Vent Care and were receiving services from another agency. The DON indicated all clients she entered on the roster were receiving services from Ometta Vent Care.

7. MN Statute §626.557 Subd. 14(b)

INDICATOR OF COMPLIANCE: # 3

Based on record review and interview, the licensee failed to assess vulnerabilities and develop an individual abuse prevention plan for one of one client (A18) record reviewed who was admitted after October 30, 2008.

Client A18 was admitted to the agency on November 19, 2008. The client's record did not contain an assessment of vulnerabilities or an abuse prevention plan. When interviewed on January 7, 2009, the director of nursing stated she had only been employed by the agency for a month and she was not aware an abuse prevention plan had not been developed for the client.

A draft copy of this completed form was faxed to Barb Currin, Administrator, on January 15, 2009. Attempts to arrange a phone exit conference were made January 14 and 15, 2009, but the administrator never returned the reviewers telephone calls to arrange for an exit conference. Any correction order(s) issued as a result of the on-site visit and the final Licensing Survey Form will be sent to the licensee. If you have any questions about the Licensing Survey Form or the survey results, please contact the Minnesota Department of Health, (651) 201-4301. After review, this form will be posted on the MDH website. CLASS A Licensed-only Home Care Provider general information is available by going to the following web address and clicking on the Class A Home Care Provider link:

http://www.health.state.mn.us/divs/fpc/profinfo/cms/casemix.html

Regulations can be viewed on the Internet: http://www.revisor.leg.state.mn.us/stats (for MN statutes) http://www.revisor.leg.state.mn.us/arule/ (for MN Rules).

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7003 2260 0000 9972 1282

July 9, 2008

Barbara Currin, Administrator
Ometta Vent Care Services Inc.
3140 Harbor Land N STE 250
Plymouth, MN 55447

Re: Results of State Licensing Survey

Dear Ms. Currin:

The above agency was surveyed on June 9, 10, 11, and 12, 2008, for the purpose of assessing compliance with state licensing regulations. State licensing deficiencies, if found, are delineated on the attached Minnesota Department of Health (MDH) correction order form. The correction order form should be signed and returned to this office when all orders are corrected. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me, or the RN Program Coordinator. If further clarification is necessary, I can arrange for an informal conference at which time your questions relating to the order(s) can be discussed.

A final version of the Licensing Survey Form is enclosed. This document will be posted on the MDH website.

Also attached is an optional Provider questionnaire, which is a self-mailer, which affords the provider with an opportunity to give feedback on the survey experience.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call our office with any questions at (651) 201-4301.

Sincerely,

Jean M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosures

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Deb Peterson, Office of the Attorney General—MA Fraud

01/07 CMR3199

Class A Licensed-Only Home Care Provider

LICENSING SURVEY FORM

Registered nurses from the Minnesota Department of Health (MDH) use this Licensing Survey Form during on-site visits to evaluate the care provided by Class A Licensed-Only Home Care Providers. Class A licensees may also use this form to monitor the quality of services provided to clients at any time. Licensees may use their completed Licensing Survey Form to help communicate with MDH nurses during an on-site regulatory visit.

During an on-site visit, MDH nurses will interview staff, clients and/or their representatives, make observations and review documentation. The survey is an opportunity for the licensee to describe to the MDH nurse what systems are in place to provide Class A Licensed-Only Home Care services. Completing this Licensing Survey Form in advance may facilitate the survey process.

Licensing requirements listed below are reviewed during a survey. A determination is made whether the requirements are met or not met for each Indicator of Compliance. This form must be used in conjunction with a copy of the Class A Licensed-Only Home Care regulations. Any violations of the Class A licensing requirements are noted at the end of the survey form.

Name of Class A Licensee: OMETTA VENT CARE SERVICES INC

HFID #: 23485

Date(s) of Survey: June 9, 10, 11, and 12, 2008

Project #: QL23485004

Indicators of Compliance	Outcomes Observed	Comments
1. The provider accepts and retains clients for whom it can meet the needs. **Focus Survey** • MN Rule 4668.0140 **Expanded Survey** • MN Rule 4668.0050 • MN Rule 4668.0060 Subp. 3, 4 and 5 • MN Rule 4668.0180 Subp. 8	• Clients are accepted based on the availability of staff, sufficient in qualifications and numbers, to adequately provide the services agreed to in the service agreement. • Service plans accurately describe the needs and services and contain all the required information. • Services agreed to are provided Clients are provided referral assistance.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued X___Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
2. The provider promotes client rights. **Focus Survey** • MN Rule 4668.0030 • MN Statute §144A.44 **Expanded Survey** • MN Rule 4668.0040 • MN Rule 4668.0170	• Clients' are aware of and have their rights honored. • Clients' are informed of and afforded the right to file a complaint.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued _X_Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
3. The provider promotes and protects each client's safety, property, and well-being. **Focus Survey** • MN Statutes §144A.46 Subd. 5(b) • MN Statute §626.556 • MN Statutes §626.557 **Expanded Survey** • MN Rule 4668.0035	• Client's person, finances and property are safe and secure. • All criminal background checks are performed as required. • Clients are free from maltreatment. • There is a system for reporting and investigating any incidents of maltreatment. • Maltreatment assessments and prevention plans are accurate and current.	**Focus Survey** _X_Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** _X_Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
4. The provider maintains and protects client records. **Focus Survey** • MN Rule 4668.0160 **Expanded Survey** [Note: See Informational Bulletin 99-11 for Class A variance for Electronically Transmitted Orders.	• **Client records are maintained and retained securely.** • **Client records contain all required documentation.** • Client information is released only to appropriate parties. • Discharge summaries are available upon request.	**Focus Survey** _X_Met ____Correction Order(s) issued _X_Education Provided **Expanded Survey** _X_Survey not Expanded ____Met

Indicators of Compliance	Outcomes Observed	Comments
Non-compliance with this variance will result in a correction order issued under 4668.0016.]		____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
5. The provider employs and/or contracts with qualified and trained staff. **Focus Survey** • MN Rule 4668.0100 • [Except Subp. 2] • MN Rule 4668.0065 **Expanded Survey** • MN Rule 4668.0060 Subp. 1 • MN Rule 4668.0070 • MN Rule 4668.0075 • MN Rule 4668.0080 • MN Rule 4668.0130 • MN Statute §144A.45 Subd. 5 [Note: See Informational Bulletin 99-7 for Class A variance in a Housing With Services Setting. Non-compliance with this variance will result in a correction order issued under 4668.0016.]	• Staff, employed or contracted, have received all the required training. • Staff, employed or contracted, meet the Tuberculosis and all other infection control guidelines. • Personnel records are maintained and retained. • Licensee and all staff have received the required Orientation to Home Care. • Staff, employed or contracted, are registered and licensed as required by law. • Documentation of medication administration procedures are available. • Supervision is provided as required.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued _X_Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
6. The provider obtains and keeps current all medication and treatment orders [if applicable]. **Focus Survey** • MN Rule 4668.0150 **Expanded Survey** • MN Rule 4668.0100 Subp. 2 [Note: See Informational Bulletin 99-7 and 04-12 for Class A variance in a Housing With Services setting with regards to medication administration, storage	• Medications and treatments administered are ordered by a prescriber. • Medications are properly labeled. • Medications and treatments are administered as prescribed. • Medications and treatments administered are documented. • Medications and treatments are renewed at least every three months.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued _X_Education Provided **Follow-up Survey** #___ ____New Correction

Indicators of Compliance	Outcomes Observed	Comments
and disposition. Non-compliance with this variance will result in a correction order issued under 4668.0016.]		Order issued ____Education Provided
7. The provider is licensed and provides services in accordance with the license. **Focus Survey** • MN Rule 4668.0019 **Expanded Survey** • MN Rule 4668.0008 Subp. 3 • MN Rule 4668.0012 • MN Rule 4668.0060 Subp. 2 and 6 • MN Rule 4668.0180 • MN Rule 4668.0220 Note: MDH will make referrals to the Attorney General's office for violations of MN Statutes 144D or 325F.72; and make other referrals, as needed.	• Language requiring compliance with Home Care statutes and rules is included in contracts for contracted services. • License is obtained, displayed, and renewed. • Licensee's advertisements accurately reflect services available. • Licensee provides services within the scope of the license. • Licensee has a contact person available when a para-professional is working.	**Focus Survey** _X_Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** _X_Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
8. The provider is in compliance with MDH waivers and variances. **Expanded Survey** • MN Rule 4668.0016	• Licensee provides services within the scope of applicable MDH waivers and variances	*This area does not apply to a Focus Survey.* **Expanded Survey** _X_Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Please note: Although the focus of the licensing survey is the regulations listed in the Indicators of Compliance boxes above, other rules and statutes may be cited depending on what system a provider has or fails to have in place and/or the severity of a violation. The findings, of the focused survey may result in an expanded survey.

SURVEY RESULTS: ____ All Indicators of Compliance listed above were met.

For Indicators of Compliance not met, the rule or statute numbers and the findings of deficient practice are noted below.

1. MN Rule 4668.0040 Subp. 1

INDICATOR OF COMPLIANCE: # 2

Based on record review and interview, the licensee failed to provide clients with a written notice related to the procedure for making a complaint for two of two clients (A1 and A2) reviewed. The findings include:

Clients A1 and A2 records lacked evidence the clients had not been provided with a written notice related to the procedure for making a complaint. When interviewed on June 11, 2009 the administrator confirmed the clients did not receive a written notice of the complaint procedure.

2. MN Rule 4668.0075 Subp. 2

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview the licensee failed to ensure employees received complete orientation to home care for three of three (AA, AB, and AC) employees reviewed the findings include:

Employees AA, AB, and AC records lacked evidence the employees received training on the overview of the regulations, handling of emergencies and use of emergency services, reporting the maltreatment of vulnerable minors or adults, handling of client complaints, and the services of the ombudsman. When interviewed on June 10, 2008 the administrator stated they had been trained in the bill of rights but not any of the other areas.

3. MN Rule 4668.0100 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on observation, record review and interview the licensee failed to ensure unlicensed personnel were trained in medication administration and reported the administration of pro re nata medications (PRN) to the registered nurse (RN) for two of two unlicensed personnel (AB and AC) reviewed. The findings include:

Employee AB was hired May of 2008 as an unlicensed care giver. Employee AB was observed on June 10, 2008 administering medications to client A1. Employee Abs' record lacked evidence she had received training by a registered nurse in medication administration. When interviewed on June 10, 2008 employee AB indicated she was a trained medication aide (TMA) and had worked as a TMA at her previous employment. When interviewed on June 10, 2008 the administrator confirmed employee AB had not received medication administration training or competency evaluation at this agency.

Client A1s' May 2008 medication administration record (MAR) indicated that on May 10, 2008 client A1 received a PRN dose of Tylenol 650mg per G-tube administered by employee AC, an unlicensed staff. Client A1s' record lacked evidence the administration of this PRN medication was reported to the registered nurse. When interviewed on June 10, 2008 the RN stated the TMA was to tell the RN of the need for the PRN medication, the RN was to assess the client, and then the PRN medication would be given. The RN confirmed she had not been informed within 24 hours that client A1s'had been given.

4. MN Rule 4668.0100 Subp. 3

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview the licensee failed to ensure that unlicensed personnel did not inject medications for two of three unlicensed personnel (AC and AD) reviewed. The findings include:

Client A1s' May 2008 medication administration record (MAR) contained a physicians order dated May of 2008 for Rocephin 1 gram IV every day for ten days. Client A1s' MAR indicated employee AC, an unlicensed care giver, initialed as having administered the medication in May of 2008 and employee AD, an unlicensed care giver, initialed as having administered the medication in May of 2008. When interviewed, June 10, 2008 the registered nurse confirmed that the unlicensed employees administered the Rocephin.

Client A2s' April 2008 MAR contained physician orders dated March of 2008 for enoxaparin sodium 40 milligrams (mg) injected subcutaneously (SQ) daily and dated April of 2008 for Heparin 5000 units SQ every twelve hours. Client A2s' April 2008 MAR indicated employee AC injected enoxaparin sodium on April 1, 2008 and Heparin 5000 units SQ on April 26, 27, and 28, 2008, Client A2s' May 2008 MAR indicated unlicensed staff injected Heparin 5000 units on May 4, 13, 14, 19, 20, 21, 22, 23, 26, 28, 29, and 30, 2008 When interviewed on June 10, 2008 the registered nurse confirmed the unlicensed personnel AB & AC had administered the medications to the client and was unaware that unlicensed personnel could not inject medications. When interviewed on June 10, 2008 the registered nurse confirmed the unlicensed personnel AB & AC had administered the medications to the client and was unaware that unlicensed personnel could not inject medications. When interviewed on June 10, 2008 employee AB confirmed she had injected the Heparin.

5. MN Rule 4668.0100 Subp. 4

INDICATOR OF COMPLIANCE: # 5

Based on observation, record review and interview, the licensee failed to ensure there were written procedures in the client's record for one of one current client (A1) reviewed. The findings include:

Client A1's plan of care dated April of 2008 indicated client A1 received tracheotomy care, tube feeding, medications per g-tube, continuous use of a ventilator at night, nebulizer treatments, and range of motion from unlicensed care givers. There were no written directions for how to do these procedures in the client's record. When interviewed, June 10, 2008 the registered nurse confirmed there were no written procedures in the client's record and there were no written procedures at the nurse's station or in the client's apartment.
When interviewed, June 10, 2008 the administrator stated there were policies and procedures for checking for residual, tracheotomy care, tube feeding, and medications per g-tube, vent care and nebulizer treatments at the office and provided a copy for review.

6. MN Rule 4668.0100 Subp. 9

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) supervised unlicensed personnel who performed services that required supervision for two of two clients' (A1 and A2) records reviewed. The findings include:

Client A1 began receiving services, April of 2008 which included tracheotomy care, tube feeding, and medication administration, range of motion and assistance with activities of daily living. Client A2 began receiving services, March 28, 2008 which included medication administration ventilator care, tube feeding, tracheotomy care, and assistance with activities of daily living. Client A1 and A2 s' records lacked evidence that a supervisory visit was completed every 14 days.

When interviewed, June 10, 2008 both the administrator and the RN stated they were not aware that supervisory visits needed to be completed.

7. MN Rule 4668.0130 Subp. 3

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that unlicensed persons who performed home health aide tasks successfully completed training or demonstrated competency in the required topics, for two of two unlicensed employee (AB and AC) record reviewed. The findings include:

Employees AB and AC were hired May of 2008 and January of 2008 respectively as an unlicensed personnel to perform home health aide tasks. There was no record of employee AB or AC receiving training in observation, reporting and documentation of client status, maintenance of a clean safe, and healthy environment, appropriate and safe techniques in personal hygiene, grooming, bathing, skin care, care of the teeth and gums, assistant with toileting, adequate nutrition, basic meal preparation, and special diets, communication skills, and physical, emotional and developmental needs of clients. When interviewed, June 11, 2008 the administrator confirmed there was no record of the unlicensed employee receiving the training. When interviewed on June 10, 2008 employee AB stated she had not been trained by the RN. She said she had been trained by unlicensed care aides.

8. MN Rule 4668.0140 Subp. 1

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview the licensee failed to ensure a written service agreement was developed for two of two clients (A1 and A2) reviewed. The findings include:

Clients A1 and A2 began receiving services on April of 2008 and March of 2008 respectively. Client A1 and A2 records lack evidence that a service agreement had been developed. When interviewed, June 10, 2008 the administrator confirmed service agreements had not been developed.

9. MN Rule 4668.0150 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview the licensee failed to ensure medications and treatment were administered at ordered for two of two clients (A1 and A2) reviewed. The findings include:

Client A1 had a physician order dated April 24, 2008 for normal saline (NS) 0.9% 200cc's every four for four times daily to flush the g-tube. The April 2008 medication administration record (MAR) indicated the client only received the g-tube, NS flush twice a day on April 25, 26, 27, 28, 29, and 30, 2008.

The May 2008 MAR indicated the client received the g-tube, NS flush three times a day, instead of four times daily as ordered, on May 4, 5, 6, 7, and 11, 2008, two times daily on May 1, 2, 25, 26, 27, 28, 29, and 30, 2008, once daily on May 9, 14, and 15, 2008. It was not documented as being administered on May 8, 17, 18, 19, 20, 21, 22, 23, and 24, 2008.

Client A1s' May 2008 MAR indicated the client had an order dated May 9, 2008 for a PICC Line dressing change, change the PICC Line cap every three days and that the PICC Line was to be flushed with five cc's of normal saline twice daily. The May 2008 MAR lacked documentation the dressing change and cap change to the PICC Line was done on May 11, 14, 17, and 29, 2008. The PICC Line was documented as being flushed with normal saline one time a day, instead of the five times daily as ordered, on May 12, 14, 15, 19, 21, 22, 23, 26, and 29, 2008 and was not documented as ever being flushed with normal saline on May 11, 13, 16, 17, 18, 20, 24, 25, 27, 28, and 20, 2008.
When interviewed, June 10, 2008 the registered nurse (RN) confirmed the above treatments were not documented as being given. When interviewed the same day the licensed practical nurse stated the reason why the treatment to the PICC line was not documented as being done on May 11, 14, 17, and 29, 2008 was because they did not get the supplies until May 20, 2008.

Client A2s' record contained a physician's order dated March 28, 2008 for Albuterol-impratropium (Duonebs) four times daily and Albuterol-impratropium (Combivent) 4 puffs four times daily. Client A2s' April 2008 medication administration record lacked evidence the Albuterol-impratropium (Duonebs) were administered to the client. The April 2008 MAR also indicated the Combivent was only administrated one time on April 1, 2, 3, 4, 5, 6, 7, 8, and 9, 2008.

Client A2 also had a medication administration order dated March 28, 2008 for Amlodipine (Norvasc) 10 milligrams (mg) one tablet daily. The April 2008 MAR indicated the Amlodipine was administered twice a day on April 1, 2, 3, 5, and 6, 2008. The Amlodipine was not administered to the client on April 4, 2008. The April 2008 MAR also indicated the client was to receive Nystatin external powder applied to skin twice a day. The Nystatin was documented as being applied once on April 1, 2008 and not applied on April 2, 3, 4, 5, and 6, 2008. The April 2008 MAR also indicated the client was to receive 100 milliliters (ml) of water by feeding tube three times daily. The MAR indicated the client received the water twice daily on April 2, 2008, once daily on April 3, 2008, that it was not given on April 4, 5, and 6, 2008. The April 2008 MAR indicated the client was to receive tracheotomy care twice a day and g-tube care twice a day. These treatments were documented as being done only once a daily on April 1, 3, 7, and 8, 2008 and not documented as being done on April 2, 4, 5, 6, and 7, 2008. Client A2 was hospitalized, April 9, 2008 and returned from the hospital April 25, 2008 with orders for Pepcid 20mg every morning, Depakote 250 mg twice daily, Septra DS one tablet twice daily, Duonebs three times

daily, Geodon 20mg twice daily, Lorazepam 2 mg every eight hours, and 200 cc's of free water every eight hours per feeding tube. Client A2s' April 2008 MAR indicated Pepcid 20mg was not given on April 26,2008, Depakote 250mg was not given on April 26, 2008, Septra DS was only given one time on April 26 and 28, 2008, Duonebs were only given twice on April 26, 2008, Geodon 20mg was not given on April 26, 2008, Lorazepam 2mg was not given on April 26, 2008, and only twice on April 30, 2008, and Free water 200cc was not given on April 26, 2008, only once on April 27, 29, and 30, 2008. Client A2s' May 2008 MAR indicated the Lorazepam 2mg was given only once on May 8, 2008, was given twice on May 1, 9, 10, and 22, 2008, the free water 200cc was not documented as being given on May 3, 10, and, 17, 2008, was documented as only being given once on May 4, 11,18,21,24, and 25, 2008, and twice on May 1, 5, 7, 8, 14, and 30, 2008. Client A2s' May 2008 Mar indicated tracheotomy care and G-Tube care was to be completed twice daily. The May 2008 MAR indicated cares were not done on May 3, 4, 10, 11,17, 18,24, and 25, 2008 and were documented as begin completed once daily on May 6 and 30, 2008.

When interviewed, June 10, 2008 the registered nurse confirmed there was no evidence the medications and treatments were given as ordered.

A draft copy of this completed form was left with Barbara Currin at an exit conference on June 12, 2008. Any correction order(s) issued as a result of the on-site visit and the final Licensing Survey Form will be sent to the licensee. If you have any questions about the Licensing Survey Form or the survey results, please contact the Minnesota Department of Health, (651) 201-4301. After review, this form will be posted on the MDH website. CLASS A Licensed-only Home Care Provider general information is available by going to the following web address and clicking on the Class A Home Care Provider link:

http://www.health.state.mn.us/divs/fpc/profinfo/cms/casemix.html

Regulations can be viewed on the Internet: http://www.revisor.leg.state.mn.us/stats (for MN statutes) http://www.revisor.leg.state.mn.us/arule/ (for MN Rules).